State Employee Benefits Committee
Monday, June 27, 2011, 2:00 p.m.
Tatnall Building, Room 112
Dover, Delaware

The State Employee Benefits Committee met on June 27, 2011 at the Tatnall Building, Room 112, Dover, Delaware. The following Committee members and guests were present:

Ann Visalli, Director, OMB
Brenda Lakeman, Director, OMB, SBO
Faith Rentz, Deputy Director, OMB, SBO
Ann Skeans, SBO
Mike Morfe, Aon – Hewitt Consultant
Vicki Ford, OMB, Financial Operations
Casey Oravez, OMB, Financial Operations
Mary Thuresson, OMB, SBO
Andrew Kerber, DOJ
Russ Larson, Controller General
Tom Cook, Secretary of Finance
Chip Flowers, Treasurer
Erika Benner, Treasurer's Office
Kelly Callahan, Treasurer's Office
Carolyn Berger, Justice, Supreme Court
Kim Vincent, Pension Office
Veronica Barnes, PHRST
Terry Mullaney, PHRST
Monica Gonzalez-Gillespie, OMB, HRM
Rebecca Steele, OMB, Budget Development
Pat Griffin, SEBAC Chair, AOC
Mary Cook, SEBAC, DOE
Tim Barchak, DSEA
Andrew Brancati, Blue Cross Blue Shield DE
Faith Joslyn, Blue Cross Blue Shield DE
Chris Ulrich, U of D
Joe Marocco, HMS
Mike North, Aetna
Katherine Impellizzeri, Aetna
Lisa Carmean, City of Milford
Karol Powers-Case, DRSPA
Barbara Jacobs, DSEA-R
James Harrison, DSEA-R
Jim Testerman, DSEA-R
Rich Phillips, DSEA-R

Agenda Items Discussed:

Introductions/Sign In

Ms. Visalli called the meeting to order at 2:05 p.m. A reminder was given to sign the attendance and/or public comment sheets. Introductions around the room followed.

Approval of Minutes

After time for review, Ms. Visalli requested a motion to approve the minutes from the April 19, 2011, SEBC meeting. Controller General Larson made the motion and Ms. Benner seconded the motion. Upon unanimous voice vote the minutes were approved.

Directors Report – Brenda Lakeman

An update from Open Enrollment (OE) in May was given. Of nearly 35,000 active state employees eligible for benefits, almost 17,500 logged on to eBenefits to verify their benefits or to make changes. Of the 22,000 plus pensioners, the Pension Office received almost 8,000 applications for changes and/or enrollments.

In the new Consumer Directed Health plans, 720 people enrolled, which is a little over 1 ½ percent of active employees and non-Medicare eligible pensioners. About 45 percent of enrollment is in the Comprehensive PPO, 33 percent in the Blue Care HMO and about 12 ½ percent in the Aetna HMO. The remainder of eligible employees and retirees enrolled in the First State Basic plan or waived benefits.

The new EyeMed vision plan enrollment is 14,641, which is down about five percent from the previous year's enrollment in the VSP plan. Mostly it was due to a decrease in pensioner enrollment.

In terms of enrollment of dependents over 21, we gained 1,739 dependents between ages 21 and 25 or up to 26. In the age bracket of 21 to 26 in general, it was a 72 percent increase and a 40 percent increase in the 21 to 23 bracket, which is who was covered before July 1. If we take the 1,739 and use the lowest per member, per year average expenses, which is $2,206 for the First State Basic, the estimated costs are $3.8 million (M). Using the average across all contracts, which is $4,934, the estimated costs are upwards of $4.6 M. Our early estimates were $5 M.

Regarding Coordination of Benefits (COB) noncompliance, reports were received last week from the carriers containing those spouses and adult dependents, whose contract holder did not complete the required forms during Open Enrollment (OE). Between Blue Cross and Aetna, there were almost 2,000 spouses that did not have a form on file at the close of OE. That is about ten percent of the population of contracts covering spouses. For the adult dependents, approximately 20 percent (800 contract holders) were found to have not completed the COB form. This week letters will be sent out to the population, asking them to complete the required form and letting them know their spouse/dependent will be sanctioned. That means we only pay 20 percent of their claims until the form is received, at which time we remove the sanction retroactive to July 1. Ms. Visalli asked if Spousal COB noncompliance was higher, to which Ms. Lakeman stated no, it is about the same as last year. Ms. Visalli also asked if there were any patterns with certain agencies having a higher percentage of noncompliant employees. Ms. Lakeman was not sure as the Benefits Office had not researched the reports by agency; however, she explained that agencies had been notified and provided a list of employees who had not completed the forms. Questions were answered about COB requirements for double state share employees.

Health Fund Financials – Vicki Ford (handout)

April and May 2011 Fund and Equity reports were reviewed. The April ending balance was $35.6 M. May's balance as of May 31, 2011 was $30.1M. There was an inquiry about moving Medicare Part D Subsidy cash received in fiscal year 2011, which is $10.2 M, to the OPEB Trust Fund. A motion will be needed for that.

Ms. Visalli reminded Committee members of the discussion they had earlier in the year on this topic and their agreement to wait until the last meeting of the Fiscal Year. The vote needs to be taken after the Public Comment. When the motion is made, groups with Medicare retirees that participate in the Health Fund will also receive their proportionate share of the Medicare Part D funds. What will go to OPEB will be something less than the $10.2 M.

Justice Berger asked why it looked like operating expenses had gone up $9 M in one month between April and May and also asked if it was due to an increase in claims. Ms. Ford noted there were four weeks of claim payments in April and May resulted in an extra week of claim payments which contributed to the increase in operating expenses. Justice Berger clarified by saying that it wasn't a change in trend, just a matter of days. Ms. Lakeman confirmed it was timing.

Mr. Morfe presented the FY11 Third Quarter Financial Reports (handout). Detailed explanation of the charts and graphs was given. Overall, the incurred medical claims and expense trend is still relatively low. Three quarters over three quarters it is up slightly at 4.1 percent. The third quarter of the last FY was an unusually good quarter. Using quarters to analyze expenses and trend helps to smooth out the five

versus four week months. The premium increase appears high due to the premium moratorium in FY10; however, is actually less than 4% on a per contract per year basis. There was a small growth in enrollment. The First State Basic plan had a very small enrollment. The rest of the contracts were consistent with the overall claim experience. The pre 65 retirees are showing a loss of 40 to 45 percent. There were no surprises in the third quarter financials.

Ms. Visalli asked if in the fourth quarter they were seeing any anomalies or expect to be on track. Mr. Morfe explained that everything has looked very flat over the year. No surprises are expected.

Group Health Insurance Program Eligibility & Enrollment Rules – Proposed Changes – Brenda Lakeman (3 handouts)

The handouts included the Eligibility and Enrollment Rules in effect as of November 1, 2009, the revised Rules effective August 1, 2011 and a summary of the changes.

All were asked to look at the "Proposed Substantive Changes" handout as Ms. Lakeman summarized the proposed changes. Most of the items were to account for the changes in coverage of dependents to age 26 as required in the Patient Protection and Affordable Care Act. Some items were being proposed as a result of administrative operations. All changes were thoroughly explained and questions answered.

Section I, Eligibility and Enrollment, added language under Section 1.01. It lists all the different groups eligible to participate in our plan; employees, full and part time, pensioners, etc. There is sometimes confusion that these groups are not only eligible to enroll but also eligible for state share. They want to include a statement that says "enrollment in state plan is not indicative of eligibility to receive state share contributions." The section on eligibility for state share contributions is covered in Section V.

Section II is about the dependents eligible to participate. The current Section 2.01b through d language has been replaced to reflect the change. Ms. Lakeman reviewed the current and proposed new language. Section B addresses children born to or legally adopted by employees or pensioners can be covered up to age 26. Section C is a change from the current rules and addresses those children who do not meet the requirements of Section B. Dependents not born to or legally adopted by the employee or pensioner can be covered under the age of 19 or up to 24 if a full time student. They do have to be unmarried and dependent on the employee or pensioner for at least 50 percent of support, reside with that employee or pensioner and they must complete a statement of support to cover that dependent.

Justice Berger asked who was in that category. Ms. Lakeman stated grandchildren, nieces and nephews that are under the legal guardianship of our employees or pensioners. They are required to have legal documentation that shows they are guardians of those dependents.

Section II, D and E simply extend those ages out past 24 or 26, should those dependents be handicapped. They have to be covered by the employer or pensioner prior to that limiting age of 24 or 26.

A note was added about the requirement to complete the Adult Dependent Coordination form. The language on the Adult Dependent Program, which was a result of HB 446 some years ago that extended coverage to 24 if your child was not a full time student has been removed as it is no longer applicable. A section was added to mandate that agencies maintain employee files with regard to documentation for enrollment and eligibility of dependents. Quarterly random audits are done to verify dependent eligibility. Some agencies and schools have asked if when they receive documentation such as birth

certificates and marriage licenses if they need to maintain them. Our answer is yes, so we can audit and ensure we are covering only eligible dependents. This verifies the agency has to maintain those files.

Section III, 3.01, a note was added about the Adult Dependent Coordination Form. There is also a separate Dependent Coordination of Benefits Form that must be completed for each enrolled dependent, regardless of age, upon request to determine if the dependent is covered by any other health plan. That was clarified in the language.

Section III, 3.09, pertains to employees and spouses who are both employed by the state and eligible for state share. They can have separate contracts, but it is often questioned if can they cover each other on their separate contracts. This section clarifies that separate contracts are allowed; however, no one individual can be enrolled under more than one contract.

Section IV includes a reiteration of the requirement to complete the Adult Dependent Coordination of Benefits Form.

Section IV, 4.12, clarifies that when a pensioner or their dependent is eligible for Medicare, they have to enroll in Medicare Part A and B when first eligible and may enroll in the Medicare Supplement Plan. They cannot remain enrolled in a non Medicare plan once eligible for Medicare.

Section V, 5.17 is clarified to revise "prior to hire eligibilities state share" to read "to be eligible for state share".

Section V, 5.21 adds language that the state can collect monies paid on behalf of an employee or dependent where premiums or claims have been paid by the state. The following was proposed: "In the event that the state has paid the employee's share or any co-pays, co-insurance, deductible or other amounts that OMB determines should have been paid by the regular officer or employee or covered spouse or dependent of the regular officer or employee, then the state may recover such amounts from the regular officer or employee by deducting the amount paid by the state from the after tax pay due to the regular officer or employee." Examples were given where this situation occurs.

Section VII, 7.05 changes a through d related to termination dates to section a through c to coincide with ages and dependent requirements contained in the revised section 2.01 b through d above.

Section X, regarding dental coverage is revised to include the vision plan in effect as of July 1, 2011.

Ms. Visalli asked if there were questions. Controller General Larson asked to go back to Section V concerning collection and clarify what happens in the first example given. Ms. Lakeman provided a detailed response on the process. Ms. Visalli stated a motion for approval would be done after Public Comments were given.

Treasurer Flowers had additional questions concerning the same section. He asked if the SEBC had authority to come back later and deduct that money or if that had to be amended in the Code. Discussion followed. Ms. Visalli stated that employees are advised of this when they enroll in health benefits. Mr. Kerber explained this was something that should have been deducted all along. Treasurer Flowers had concern that it could be taken after tax, when originally it would be taken pre-tax. After further discussion, it was asked if they need to check the IRS Rules. Ms. Lakeman assured they would inform the employee before deductions were taken. Controller General Larson also had concerns if they knew

when they filled out forms to enroll in health benefits that they had to pay a certain amount. Ms. Lakeman confirmed they did. In the past, Ms. Lakeman stated they never took out more than $100 from a paycheck. They work with the employee so it does not create a hardship. In the end if they say no, they don't want to repay, the Benefits Office would like some recourse to be able to say they are going to take out a reasonable amount from their paycheck each pay period. Ms. Visalli suggested at the time they make the motion, they approve the rules as presented with the understanding that the Benefits Office will circle back to the SEBC on any additional information obtained and provide assurance that the proper authority is in place to exercise this section of the revised rules.

Early Retiree Reinsurance Program Update – Brenda Lakeman

Ms. Lakeman reported that with the passage of Patient Protection and Affordable Care Act, the Early Retiree Reinsurance Program (ERRP) allowed the State to recoup the costs of non Medicare retirees who had incurred expenses over $15,000 and less than $90,000. In December 2010, the State requested and received a payment of $1.4 M for claims paid in June 2010. In March 2011, another request for payment was submitted and received in the amount of $3.3M for claims paid through September 2010. In April 2011, Health and Human Services issued guidelines that future payment requests must be accompanied with detailed information related to each claim. Specific file formats must be submitted. To meet the requirements, it is necessary to obtain the information directly from the medical and prescription vendors. It is anticipated that the detailed claims information will be provided in late August and the next payment request for claims paid through June 2011 will be submitted to CMS by the end of September 2011. This submission of data will include detailed claims information to support the prior two payments received in December 2010 and March 2011.

Justice Berger expressed concerns over what impact the delay in requesting payment would have on the State's ability to receive funds. Ms. Lakeman reiterated that the State's application is approved and it is anticipated that the State will receive full reimbursement for claims paid through FY11. Controller General Larson asked about the timing of when funds would no longer be available. Ms. Lakeman explained that $5 B was allocated and it is available until exhausted or January 1, 2014, whichever comes first.

Secretary Cook asked if there was any risk that the State could lose the $4.7 M reimbursed to date. Mr. Morfe stated it is highly unlikely, but theoretically possible. Documentation will be submitted as requested, both for previous and current fiscal years. All ERRP applicants must submit the same information. Reimbursements have come to a halt and the secure website used to request payment was shut down April 1.

SEBAC Comments

Ms. Griffin explained that SEBAC had questions as to whether there was a potential impact of using Med D money for the OPEB funding and transferring from the health fund. Ms. Visalli stated it had been addressed. Mr. Morfe confirmed there is adequate funding for immediate short term expenses of the health fund. Ms. Griffin then stated "SEBAC supports transfer of additional funding to OPEB due to the State's obligations".

Public Comments

Karol Powers-Case, DRSPA, due to not having been in attendance for several months was unfamiliar with the ERRP claims and asked for explanation. Ms. Lakeman provided an explanation of the intent of the program.

Ms. Powers-Case also voiced concern over what was happening with the High Mark and Blue Cross affiliation, asking if any explanation could be given. Ms. Visalli explained it was not within purview of the SEBC.

There being no further Public Comment, Ms. Visalli asked for a motion to approve the transfer of monies for OPEB. Secretary Cook stated that with the endorsement of SEBAC he would make a motion to move the Medicare Part D Subsidy funds received in FY11, excluding those funds attributable to retirees of the participating non payroll groups, to the State's OPEB Trust. Ms. Visalli stated the amount to be $10.2 M. Secretary Cook confirmed the amount. Controller General Larson seconded the motion. Upon unanimous voice approval the motion carried.

Ms. Visalli asked for a motion to approve the Proposed Substantive Changes for the Eligibility and Enrollment Rules and the complete proposed rules effective August 1, 2011 as presented. Secretary Cook made the motion. Treasurer Flowers made the following amended motion to Section V, 5.21:

> In the event that the State has paid the employee share or any co-pays, coinsurance, deductibles on other amounts that OMB determines should have been paid by the regular officer or employee or covered spouse or dependent of the regular officer or employee, upon prior written notice to such regular officer or employee (which shall not be less than sixty days), the State, to the extent permissible under applicable law, may recover such amounts from such regular officer or employee by deducting the amount paid by the State from the after tax pay due to the regular officer or employee, (i) such regular officer or employee shall be provided an opportunity to dispute such amounts owed to the State to the Statewide Benefits Office and (ii) if the amount owed by such regular officer or employee exceeds $1,000, such regular officer or employee shall be provided an opportunity to have the amount owed deducted in monthly installments over a period of time not less than twelve (12) months.

Discussion and clarifications followed. Ms. Visalli stated there was an open motion and an amendment. She then asked for a second on the motion as amended. Treasurer Flowers seconded the motion as amended and the motion carried upon unanimous voice approval.

Other Business

Ms. Visalli noted that the Operating Budget had passed the House and was going to the Senate for consideration. She explained epilogue language that would require a Committee to explore cost saving ideas in the Medicaid and Group Health Insurance Programs.

There being no further business, Ms. Visalli asked for a motion to adjourn the meeting. Secretary Cook made the motion and Controller Larson seconded the motion. The meeting adjourned at 2:52 p.m. upon unanimous voice approval.

A reminder was given that the next SEBC meeting would be July 18 at 2:00 p.m.

Respectfully submitted,

Mary K. Thuresson
Administrative Specialist
Statewide Benefits Office, OMB